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ABSTRACT

Through direct observations of activities, conversations, and social interactions involving children with emotional or behavioral challenges, this study investigated practices child care staff used to include these children in their program, as well as child to child interactions, and supports put in place for times of transition between activities. Participants were 5 children from each of 5 model inclusive child care programs. Two independent observers recorded observations during individual 60-minute observational blocks scheduled during transitions. Eight of the children observed were designated by care giving staff as typically developing; the remaining 17 were reported as indicating emotional or behavior challenges. Mental health challenges included attention deficit hyperactivity disorder, depression, and attachment disorders. Children were of varied ethnicities, and 11 of the 25 children were male. Qualitative analysis revealed staff social initiatives to build upon strong relationships with individual children and, anticipating challenges, the staff structured schedules and environmental modification to encourage cooperation and self-regulation, physical calming, instruction of peers to respond appropriately to challenging behavior, and involvement of multiple staff to defuse crises. Children accepted differences in their peers with challenges and included them in activities and friendships. To support children in transitions, staff used predictable schedules, multiple developmentally appropriate cues, physical calming techniques, and multiple staff with well-rehearsed roles. Findings suggest that child care centers can successfully include children with mental health challenges, given appropriate supports. (Contains 29 references.) (KB)

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Inclusion of Children with Emotional or Behavioral Challenges in Child Care Settings:

An Observational Study

by

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Abstract

Through direct observations of activities, conversations, and social interactions involving children with emotional or behavioral challenges, researchers investigated: practices child care staff used to include these children in their programs; child to child interactions; and supports put in place for times of transition between activities. Two independent investigators recorded observational notes on 25 children in individual 60 minute observational blocks scheduled during transitions. Qualitative analysis revealed staff social initiatives, structured schedules, physical calming, environmental modification, and involvement of multiple staff to defuse crises. Results suggested child care centers can successfully include children with mental health challenges, given appropriate supports. To achieve inclusion on a wider basis, increased funding is required for additional services and for research on evidence-based practices.

Inclusion of Children with Emotional or Behavioral Challenges in Child Care Settings: An Observational Study

Many of the families that enroll their children in Head Start, in other early childhood education programs, or in child care, experience extreme stressors including poverty, (National Center for Children in Poverty, 1998), exposure to violence, and parental substance abuse or mental illness (Donahue, Falk, & Provet, 2000). These stressors have proven to be risk factors for developing emotional and behavioral challenges on the part of young children, especially when coupled with biological predispositions, difficult temperaments, or experiences of trauma (Cohen & Kaufmann, 2000; Donahue et al., 2000).

Surveying employed parents about their perceptions of quality concerning their child care arrangements, Emlen (1997) found that of the 862 workers who responded, 8% replied that they had a child with an emotional or behavior problem that required special attention. Children with emotional or behavioral challenges were 20 times more likely than other children to have had caregivers who quit or dismissed them from care because of behavioral problems.

Shonkoff and Phillips (2000) have argued that exclusion of children with disabilities from child care has a negative impact on those children, who are not exposed to the cognitive stimulation and powerful socialization available through child care settings in which they can interact with typically developing children. Brennan, Caplan, Ama, and Brown (2000) have also made the case that typically developing children in child care settings who are not exposed to children with disabilities, including emotional and behavioral challenges, are not being prepared for life in inclusive schools or a diverse society.

Moreover, when a child has an emotional or behavioral disorder, finding a suitably nurturing child care setting with providers who can cope with physical, behavioral, or emotional

challenges may be both difficult and costly for parents (Brennan & Poertner, 1997; Friesen, Brennan, & Huff, 1999; Harvey, 1998; Kagan, Lewis, & Heaton, 2001; Rosenzweig, Brennan, & Ogilvie, in press; Warfield & Hauser-Cram, 1996). Locating a setting that includes children with challenges along with typically developing peers may seem to be an impossible quest due to the lack of support in many early childhood environments for such children's special mental health needs (Irwin, Lero, & Brophy, 2000; Rafferty & Boettcher, 2000)

As part of an effort to promote inclusion of children with special needs in high quality child care, the Child Care Bureau funded the Maps to Inclusive Child Care Project, a technical assistance program which aimed at helping states to build capacity (Bruder, 1999). Through the Maps project a total of 31 states assembled teams of stakeholders, including child care providers and administrators, representatives of early childhood education and Head Start, and families of children with disabilities to engage in planning processes that would promote inclusive child care in each state. States individually set the regulations for which special needs would be considered for the inclusion plans they developed; although some states explicitly included children with mental health disorders (Butler, 1997), others did not.

Fortunately, there are child care programs where children with emotional or behavioral challenges are successfully included with typically developing peers (Brennan, Caplan, Ama, & Archer, 2001; Child Care Bulletin, 2002). In truly inclusive settings (Guralnick, 2001), children lagging behind in social and emotional development can learn to interact with supportive adults, to become part of a peer group, and to regulate their behavior and their expression of affect. At these centers, children who would benefit from early intervention can be identified and receive services, and their families can be engaged in supportive services as well.

A five year (1999-2004) research project, *Models of Inclusion in Child Care*, has been funded by the National Institute on Disability and Rehabilitation Research and the Center for Mental Health Services. The project involves the first investigation to focus primarily on programs and strategies that result in improved access of families having children with emotional or behavioral disorders to child care that is inclusive, family-centered, culturally-appropriate, and of high quality (Brennan, 2000).

The first phase of the project, *the Study of Model Inclusive Child Care Programs and Strategies*, focused on identifying, describing, and analyzing key features of a selected group of model child care programs. These inclusive programs were meeting children's needs for a nurturing, developmentally appropriate setting, family needs for quality child care for their children with emotional or behavioral challenges, and provider needs for consultation and training about emotional and behavioral disorders. In this study, inclusion is defined is the delivery of comprehensive services to children with emotional or behavioral challenges in settings that have children without these challenges, and the participation of all children in the same activities, with variations in the activities for those children whose needs dictate the adaptation (see Kontos, Moore, & Giorgetti, 1998).

This paper reports results of a preliminary analysis of data gathered in an observational investigation that examined the behavior of children and care providers in model child care settings under study by project researchers. The observations were part of a field investigation of five centers selected for onsite study from programs throughout the United States nominated for their successful inclusion of children with emotional or behavioral disorders.

Observations were focused on the following major research questions: (1) What are the ways in which caregivers work toward inclusion of the child in activities and in social

interactions? (2) Do child-to-child interactions give evidence of inclusion? (3) In what ways is the child supported by center staff during transition periods?

Method

Selection of Centers

A total of 104 programs were designated for possible inclusion in the study by means of a brief nomination instrument which was circulated to the Child Care Administrator of each state, child care information and referral services, and the state liaisons to the Map to Inclusive Child Care Project, as well as to statewide or regional family support organizations which served families with children and youth affected by emotional or behavioral disorders. Thirty-four of the nominated programs participated in a mailed survey gathering program characteristics.

A coordinating committee consisting of child care experts, former child care providers, a special educator, researchers, and family members having children with mental health challenges chose five centers for site visits, based on the characteristics they reported in the survey. The centers were invited to participate on the basis of meeting study criteria requiring high quality programs, culturally competent services, family participation, and full inclusion of children with emotional or behavioral challenges alongside children with typical development. Additionally, the centers were selected so that they represented diverse populations, enrollment numbers, geographic locations, and service delivery patterns, as can be seen in Table 1.

Table 1

Characteristics of inclusive child care centers that served as observational sites

	Center Name				
Center Characteristic	Broken Arrow Clubhouse	Family Resource Center	Fraser School	Little Angels Child Care Center	St. Benedict's Special Children's Center
Location	Broken Arrow, OK	Lanier, NC	Bloomington, MN	Milwaukie, OR	Kansas City, KS
Location Type	Suburban/ Rural	Rural	Suburban	Suburban	Urban
Ages Served	3-13 years	Birth-8 years	Birth-6 years	Birth-6 years	Birth-5 years
Program Types	Preschool, Kindergarten; Before-After School; Summer.	Infant-Toddler Care; Preschool; Respite Care.	Infant-Toddler Care; Preschool.	Infant-Toddler Care; Preschool, Respite Care.	Infant-Toddler Care; Preschool.
Approximate Enrollment Size	100	150	325	37	80
% with Emotional/ Behavioral Challenges	40	15	11	8	50
% Families below Poverty Level	19	20	14	11	80
% Ethnicity of Children					
African American	2	2	12	8	40
Asian American	0	0	3	0	5
European American	87	91	81	87	5
Hispanic/Latino	5	5	1	5	50
Native American	6	1	1	6	0
Mixed Heritage	0	1	0	0	0

Participants

Five children from each of the five child care centers visited were observed, for a total of 25 participants. Caregiving staff designated 8 of the children as typically developing, with the remaining 17 reported to evidence emotional or behavioral challenges. The children's mental health challenges included Attention-Deficit/Hyperactivity Disorder, depression, and attachment disorders. Children observed in the selected centers were of varied ethnicities including African

American, Asian American, European American, Native American, and Mexican American; 11 of the children were male. Participant children ranged in age from 10 months to 11 years (M = 4.2, SD = 2.1). Written consent was obtained from parents for their children to participate in the research, and children over 6 years of age also gave their assent to be observed.

Procedure

Each child was studied in natural settings by two researchers in the same one hour time block; settings included classrooms, indoor and outdoor playgrounds, art rooms, lunch settings, and napping facilities. Observational blocks were selected so that each involved times of transition such as lunch periods, going out to or coming in from play, or preparing to leave the child care center for school. Two independent researchers recorded by hand all activities, behaviors, and conversations involving the child targeted for observation during the observational block, using a semi-structured format. The resulting qualitative data were coded for major themes and subthemes by three independent coders. Coders met to reconcile differences in interpretation of the field observations, and further develop subthemes.

Results

Analyses of observation field notes revealed processes resulting in substantial inclusion of children with emotional and behavioral challenges in center activities and social interactions. Our report of results considers each of the three research questions separately, lays out the subthemes that we found in our observations, and illustrates each subtheme with an excerpt from the observational data, presented in italics.

Inclusive Practices

In answer to the first question: "What are the ways in which caregivers work toward inclusion of the child in activities and in social interactions?" four major findings emerged.

First, child care staff set up environments and routines to encourage cooperation and self-regulation. Physical and social environments were structured so that children participated in an inclusive manner in center activities. In one center caring for school aged children, an 11-year-old girl with an attachment disorder was put in charge of animal care for the center's doves. Her teacher structured the situation so that she could work with a younger child on the task, and begin to develop a relationship with him. Our notes revealed that "[*Child A*] *is the 'supervisor' of* [*Child B*] *during the dove feeding, helping him, reminding him to clean his hands. She nicely explain*[*s*] *to* [*Child B*] *that if people don't wash their hands after feeding doves they could catch diseases.* [*Child B*] *eventually washes his hands.*"

In a second recurring theme in our observations of inclusive practices, staff built upon strong relationships with individual children and anticipated social and emotional challenges. Teachers at one center anticipated the needs of a 5-year-old boy with autism spectrum behaviors and hyperactivity challenges by permitting him to take a small set of plastic trains with him from activity to activity. The trains gave him a focus for his attention, and their manipulation helped him to remain calm, even during transitions between activities. In one of several difficult situations during our observational hour his class was being moved from the lunch room into the art room of the center. "[Lead Teacher] *takes 3 of the children to next room.* [Child C]: *"Oh-oh my trains!"* [Lead Teacher]: *"Where are they?* [Child C]: *"The other room."* [The Lead Teacher gives her permission to retrieve the calming toys.] [Child C] *runs and gets them; returns to room.*

A third emergent subtheme addressing inclusion revealed that peers were taught to respond appropriately to challenging behavior and to the special needs of their classmates. Another 5-year-old boy with aggressive behavior challenges was observed at a particularly

difficult time—his last day at the preschool. After he hurt a female classmate, the lead teacher directed her attention primarily to the victim, as did the other children, who were previously taught to respond to aggression by paying primary attention to the victim. "[Child D] *is whipping his puppet around and hits a girl who starts crying.* [Lead Teacher comforts the girl who was hit] *"I'm sorry my friend hurt you.* [Child D is told by the teacher]*: 'You hurt your friend.' Another child comforts crying child. The tension with* [Child D] *disappears."* In this situation, the aggressive behavior was stopped, the outcome desired by the child care staff.

Finally, we observed in the fourth subtheme in our data that mental health service provision was integrated into scheduled center activities. Two boys were seen struggling to control their aggression at an organized soccer game in an after school program. Both a staff counselor and lead teacher were present at the game. *"Disruptive dispute between older boys* [one punches the other] *stops game. Counselor and teacher work with each boy separately. Game resumes without the two boys. The two boys finish with the adults and re-join the game."* The counselor and the teacher used this actual experience to assist the boys with anger control, to keep the other children safe, and to model the peaceful working out of disputes.

Child-to-Child Inclusive Interactions

Our second research focus targeted peer social exchanges in our model settings and responded to the question: "Do child-to-child interactions give evidence of inclusion?" Building on opportunities structured by teachers, we observed that children accepted differences in their peers with challenges and included them in activities and friendships.

An example of teacher-structured child-to-child interactions took place at a preschool activity center. A three-year-old boy with emotional and behavioral challenges was observed in a water table play activity. Another boy was also at this station and they were joined by the lead

teacher and a teaching assistant, who used the opportunity to teach social skills. "*The two boys are sharing toys, taking turns washing figurines down a slide on a water table...* [Child E] *talks about Grover getting washed down slide,* [Teaching Assistant]*: 'Is he taking turns with Winnie?'* [Child E] *says 'Grover can go,'* [Grover is the figurine the other boy is playing with.] *'It's his turn'...Both boys play with both figures, walking them around and around the water table...* [Both teachers] *are helping them by taking turns and talking to them.* In this example, the teachers made use of the time in which part of the class was attending another activity outside of the classroom for intensive social skills work and imaginative play.

A second example of child-to-child interaction involved children acknowledging differences and accepting them in their peers in outdoor playground activities. The observations centered around a 5-year-old participant with developmental and speech delays as well as emotional and behavioral challenges. She was interacting with her peers who had formed a queue to slide down the highest board in the playground. "[The Lead Teacher] *follows* [Child F who] *grabs a toy school bus from inside and brings it out.* [The Lead Teacher] *follows her to slide where* [Child F] *appears to be getting ready to slide the bus down – on top of another child sitting at the bottom.* [The teacher] *warns* [the other child] *who moves and* [Child F] *just lays there* [on top of the slide] *for awhile. Other kids come over to help her down the slide. 'Wasn't that fun?' they ask her.* [Child F] *comes back up for more. Kids help again and tell each other to watch out.* [The teacher] *asks a boy at the bottom of the slide to move some socks* [Child F has been putting on/taking her socks off repeatedly]. *The boy removes the socks while other kids at the top of the slide...*[encourage her] *to go down slide. Kids wait semi-patiently for her to go. She won't.* [The teacher] *comes over to help.* [Child F] *drops bus down and, eventually slides down herself. Other kids clap."*

A final subtheme that emerged from the data was the inclusion of children with special needs in peer activities and friendships. In a preschool art class, a 5-year-old with emotional and behavioral challenges was approached by a friendly, playful classmate. "[Child G] *paints slowly and carefully. Another child says 'Hello' through an empty cardboard tube to* [Child G, who] *ignores him and goes on painting*...[Child G declares] '*I've finished my painting.*' [and] *goes to the door.* [The other child] *hugs him: 'you're my best buddy' to* [Child G].

Support during Transitions

Our observations had been set up to especially target transitional periods so that we could explore the support staff gave during this time, and answer our third and final question: "In what ways is the child supported by center staff during transition periods?" Analysis revealed four subthemes that emerged from the observations. Staff used predictable schedules, multiple developmentally appropriate cues, and physical calming techniques to ease children with challenges through transitions, and multiple staff members with well-rehearsed roles worked to facilitate transition times.

In observing the classroom environments in the centers, researchers found that a frequent structuring device was the use of predictable schedules posted for the children. These schedules were used by teachers to remind children of transitions, referred to as the day progressed, and frequently reviewed by the teachers. Additionally, transition times were signaled by teachers to prepare children for the changes in activities that challenged so many of the children. For example, in one preschool center, a girl who had been singing the alphabet song at "Circle Time" received a prompt from her teacher to take part in a new game at an activity center, posted as activity time on the wall. "*As the teacher points to the letters,* [Child H] *recites them...Teacher announces that there is a new game; they are going to take turns with it. The children gather*

around. She says, 'I need everyone on their name.' [Child H] *complies immediately.*" Another example of cueing was seen at an outdoor game, involving a boy with behavioral challenges. "[The lead teacher] *gives group a seven minute warning* [to go inside]. [Child I] *plays by the rules set by group of children, but there is another dispute with the goalie. Counselor is there. Boys work it out...they play on. Teacher counts down time until they all need to go inside.*"

Physical calming techniques were also used by teachers to help facilitate difficult transitions for children. For one 5-year-old girl who had developmental delays and behavioral challenges, settling down for nap time was particularly problematic, and took a total of 14 minutes. "[Child J is playing] *around with her blanket and she begins to put a part of it into her mouth. Seeing this,* [the lead teacher] *sits next to her, but doesn't talk to her. When* [Child J] *puts blanket over her head,* [the lead teacher] *helps her onto cot; lays blanket on her...The lead teacher leaves the room,* [Child J disturbs]*...the chair* [the lead teacher was sitting in]; *younger teaching assistant moves chair and sits on floor next to child and rubs her back.* [Child J] *mellows out with teacher's hand on her back and falls asleep.*"

Finally, transition times were observed to involve multiple staff members playing well-rehearsed roles in order to facilitate the children's movement between the scheduled times. An example occurred at a preschool setting involving children who had been in classroom activities in two rooms coming together for free play in an indoor gym. A 4-year-old girl with multiple emotional and behavioral challenges had contact with three teachers as she made this transition, and worked to find a desirable toy to ride in the gym. "[Child K] *goes to line up spot and stands on a number, before lead teacher announces "line up." The teacher had said, 'we're going to the gym'. Her teaching assistant says, 'We are in the gym,'* [pointing to a door-sign that tells people where the class is located]...[Child K] *goes to a large bike and backs it out* [from its

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holding place]. *The teaching assistant says 'That bike doesn't work;' she gets a wagon out instead and pulls it around the floor.* [Unsatisfied, Child K] *goes to another teacher and holds her hand...*[Teacher points to functioning tricycle, and Child K] *picks up a working trike and rides behind a big group of 'bikers' who are circling the gym.* Here, the needs of the individual child were met as she felt free to appeal to different teachers who were used to working with the larger combined class, and who knew the challenges of the children in both classes.

Discussion

The study has demonstrated that staff members of child care centers are able to structure environments and social interactions that successfully include children with emotional or behavioral challenges. Using developmentally appropriate practice as a basis, staff employed techniques that addressed individual children's needs in a culturally appropriate way, facilitating their retention in the child care centers. Children in these centers were observed to have staff support as they moved through the day, learning social skills, self-regulation, and academic content. Although some highly stressful days were selected for observation at the centers (e.g., a last day in preschool, the end of the school year in an after-school program), staff were able to meet the challenges the children presented, and used the situations to teach about social skills and self-management. Staff built healthy relationships with the individual children, and used these attachments to promote social and emotional well-being (Child Care Bureau, 1997).

Typically developing children had been prepared to deal with challenging situations and seemed to be socialized to accept differences in their classmates. Our observations corresponded well to information we had obtained from interviews with staff members who discussed working with the typically developing peers (Brennan, Caplan, & Ama, 2002). Staff discussed peers

modeling healthy behaviors and social skills, and their work with the typically developing children to help them deal with the challenges their peers with mental health issues presented.

The findings of this observational study affirm the capacity of child care staff to promote social and emotional development, and for child care service providers to play an important part in integrated mental health service delivery. These natural environments are logical settings for the delivery of mental health services to the children that need them. At the March, 2001 meeting of the National Leadership Forum on Child Care and Mental Health, participants made the recommendation "Incorporate children's mental health services into existing child care and early childhood education services." (Child Care Bulletin, 2002, p. 8). The specialized resources observed in these centers, such as therapeutic equipment and onsite mental health providers (Cohen & Kaufmann, 2000; Donahue et al., 2000), were certainly instrumental in allowing the successful inclusion of children with emotional and behavioral challenges.

As child care providers work with children with mental health challenges, the availability of mental health consultation has also proven to be critical. Recently mental health consultation programs serving child care organizations have been documented and discussed at national conferences (Bowdish, 2001; Caserta & McBride, 2002; Fong & Wu, 2002). Evaluation researchers have begun to establish the success of mental health consultation in promoting gains in social maturation on the part of children with challenges (Tyminski, 2001), and have provided evidence for the achievement by these children of greater ability to stay on task, learn, tolerate frustration, and behave age-appropriately when consultation is available (Fong & Wu, 2002).

Additionally, it should be noted that the National Leadership Forum participants also recommended that mental health consultants, such as those found in Head Start programs (Yoshikawa & Knitzer, 1997), be funded for other child care settings, and that model initiatives

be supported (Child Care Bulletin, 2002). Funding must be augmented to subsidize the supports that centers require to serve the needs of children with emotional and behavioral challenges, and of their families, who frequently have been excluded from child care centers. Priority should also be given to the funding of research that can establish evidence-based practices that promote children's mental health in the natural environment of child care settings (Phillips, 2001).

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